



A PAVII "HOW-TO" ASSESSMENT PAPER

IDENTIFYING VISUAL IMPAIRMENTS IN INFANTS

by Gail Calvello

The purpose of this paper is to:

1. Identify problems associated with early diagnosis of vision impairment.
2. Describe physical indicators which constitute reasons to refer an infant to a pediatric ophthalmologist.
3. Define terms used to describe vision loss.
4. Offer a format for conducting a functional vision screening for infants.

1. FACTORS ASSOCIATED WITH DELAY IN EARLY DIAGNOSIS OF VISUAL IMPAIRMENT

A timely diagnosis may lead to remediation and/or prevention of additional vision loss. Although some visual impairments cannot be remediated, understanding the diagnosis should help parents to provide an early learning environment which is meaningful for the infant.

Visual impairments which involve anatomical abnormalities are readily identified at birth. Less obvious forms of visual impairment may not be diagnosed for several months. Factors which may contribute to a delay in diagnosis include:

- Misconceptions that infants do not see well for the first six months...
"I always thought that babies couldn't really see clearly for months."
- Symptoms may not appear for several weeks...
"His eyes were steady when he was first born; they started jumping around right after our trip back East."
- Symptoms may be intermittent...
"The only time his eyes wiggle is when he's tired."
- Children who are "cortically blind" have relatively normal appearing eyes...
"People tell me what beautiful eyes she has."

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- Parents may wait for the pediatrician to note any abnormalities...

"I thought the doctor would tell me if there was something wrong with Jamie's eyes."

- Parents may fear a diagnosis, particularly if an infant has other impairments...

"I couldn't stand the thought that one more thing might be wrong."

- Pediatric appointments are usually brief and may be focused on a specific purpose; the child may be sleepy or fussy, masking symptoms...

"Susie was either nursing or fussing during her doctor appointments; I don't think the doctor really saw her eyes for the first few visits."

- Well-baby appointments may not include vision screening...

"The nurse practitioner never asked about her vision - just about food, growth and immunizations."

- Vision problems may not be readily apparent in babies who have other physical impairments or developmental delays...

"I noticed that he didn't look at my face, but I just thought it was part of being premature."

2. REASONS TO REFER

If an infant or toddler exhibits any of these indicators, a referral should be made to a PEDIATRIC OPHTHALMOLOGIST, a physician who specializes in the diagnosis and treatment of children's eye diseases.

EYE STRUCTURE

1. Coloboma - an irregularly-shaped pupil or iris; may have a keyhole shape.
2. Cataract - an opacity of the lens; looks like a white dot in the pupil; may be visible only when child moves eyes in a certain direction.
3. Corneal Opacity - a cloudy area on the clear surface of the eyeball.

EYE MOVEMENT

1. Nystagmus - rapid or "wiggly" eye movements; may be vertical, horizontal or circular; does not appear until 6-8 weeks after birth.

2. Roving or drifting eye movements - slower than nystagmus with minimal or no attempts to focus.
3. Paradoxical pupil - pupil enlarges in bright light.
4. Strabismus - eye turns in or wanders out past midline; may appear to use one eye more than the other (amblyopia). Infants with wide nasal bridge may appear "cross-eyed" for the first few months (psuedo-strabismus).
5. Averted gaze - does not make eye contact; looks to the side or above another's face.

HEAD POSITION

1. Head tilt - consistently tilts head when focussing on an object; may be to either side or tipped up or down.
2. Field deficit - turns to objects on one side only or focuses at midline but not above or below; may notice objects in peripheral field but not at midline.

OTHER BEHAVIORS

1. Photophobia - in bright light, child may squint or close eyes, turn head away from light source; or eyes may water.
2. Perseverative behaviors - light gazing and hand - flicking may be associated with neurological problems, but visual impairment should be considered.

3. VISUAL TERMINOLOGY: WHAT DO THOSE WORDS MEAN?

The following terms are often used in assessing and diagnosing an infant's vision loss. To most people, "blind" implies a complete loss of vision; however, some physicians and other professionals may use the word to refer to any serious visual impairment. ASK FOR DEFINITIONS.

1. Legal blindness - is a measurement of distance vision, not near vision. It is defined as visual acuity less than 20/200 in the better eye after the best possible correction; or a visual field limited to 20 degrees or less, even if the acuity is normal. 20/200 means that a person sees at 20 feet what an individual with normal vision sees at 200 feet. A visual field of 20 degrees is similar to looking through a narrow tube. Many people who are legally blind can read print at close range.

2. Partially-sighted or low vision - defined as distance visual acuity ranging from 20/70 to 20/200, in the better eye after the best possible correction. A person who is partially sighted may see better under some conditions than others. Lighting conditions are often important. A person who is partially sighted may have "foggy" vision, similar to what you might see in a misted mirror.

3. No light perception (NLP) - means without sight. It does not mean that the person sees darkness.

4. Cortical blindness or cortical visual impairment- refer's to the brain's inability to perceive or decode visual images. Cortical visual impairment is the result of a cerebral injury; the eyes and the optic nerves may be intact, but the visual cortex (which receives and decodes visual images) is affected. Visual functioning may range from no apparent vision to intermittent vision. The vision loss can be transient or permanent, depending upon the age at onset and the severity of the injury.

Legal or medical definitions rarely provide all the information about an infant's vision. We need to make our own observations, gather information from parents, and keep an open mind. An infant's diagnosis may not change, but the infant's ability to use residual vision may develop and dramatically impact visual behaviors. Moreover, many factors other than diagnosis or estimated acuity affect an infant's visual functioning, e.g. intellect, motivation, and emotional and physical environment. Infants often surprise and delight us with their ability to use their residual vision.

4. FUNCTIONAL VISION SCREENING

PURPOSE

The purpose of the Functional Vision Screening Checklist is to provide a format to:

1. Identify visual skills
2. Identify variations from normal sequence of development
3. Share information with other professionals

Information obtained from the Functional Vision Screening can be used as a basis for encouraging the infant's use of functional vision.

GUIDELINES

A functional vision screening describes how a child uses vision to interact with people and objects in the environment. Vision screening should be done in a familiar setting. Program staff can integrate screening activities while playing with the infant.

A functional vision screening should include:

1. Interviewing the caregiver about observations, questions and concerns
2. Observing the infant's typical interactions with people and objects
3. Setting up activities to observe specific skills

SUGGESTIONS

- * Be aware of the location and intensity of light sources. For optimal results, light source should be behind infant.
- * Make certain the baby is securely positioned, e.g. lying on back or in an infant seat.
- * Note visual distractions, e.g. examiner's clothing, patterns of light and shadow on the wall or floor, bands of light shining through window coverings or a curtain blowing in the breeze.
- * Try to manage distractions, e.g. television or radio turned on, or children playing near the baby.
- * Consider the infant's state: Is the baby alert, sleepy, fussy, hungry, recently ill?
- * Be sensitive to the infant's social awareness. If the baby is fascinated with your unfamiliar face, use your face as the visual stimulus. On the other hand, if the infant is wary or afraid of strangers, ask the caregiver to elicit any behaviors you need to observe.
- * Get the baby's attention by combining auditory and visual stimulation, e.g. your voice and face, or by shaking a colorful rattle. Then try to elicit responses with familiar, non-sound making toys. If the baby does not focus or track, use highly contrasting, bright, or shiny objects such as tin foil, costume jewelry, or tinsel. Next try filtered lights such as a pop bead over a penlight.

- * Keep it simple. Too many colorful toys create visual clutter and may overwhelm the infant.
- * Whenever attempting to elicit responses, end the activity with something the baby can do.

This paper and the accompanying Functional Vision Screening Checklist are based on the author's experience and a review of the following references:

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FUNCTIONAL VISION SCREENING CHECKLIST

Name _____ Date of Birth _____

Date of Screening _____ Age _____

Informant _____ Observer _____

SEQUENCE OF DEVELOPMENT

OBSERVATION SUGGESTIONS

Check (✓) observed behaviors.
Write "R" for reported behaviors.

Birth - 1 month

Fixates on face and
tracks with head and eyes

In face-to-face position, at 12"-
18", does infant stare at
caregiver's face? _____

Talk to the baby and move your
face side-to-side, and up-and-
down.

Does baby track with head
and eyes? _____

NOTES:

*Pupil constricts in
bright light

Observe infant in dim and
brightly lit areas.
Does pupil react? _____

NOTES:

Observes movement in
room

Does infant track family members
or pets around room? _____

NOTES:

*A responsive pupil does not imply visual system is intact.

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SEQUENCE OF DEVELOPMENT

OBSERVATION SUGGESTIONS

Birth - 1 month (continued)

Stares at light source

Does infant notice when lights are turned off or on? ____
Patterns of sunlight on wall or floor? ____
Turn toward light source? ____

Insert a penlight in a popbead. Does infant fixate on lighted bead? ____

NOTES:

2 months

Looks directly at caregiver's eyes

Observe infant in face-to-face interaction with caregiver. Is there eye contact? ____
If not, does infant seem to focus slightly to the side, or above caregiver's eyes?

NOTES:

Watches lip movements

Does infant respond to normal and exaggerated lip movements (e.g. wide open mouth, tongue stuck out)? ____
Does infant quiet ____, stare ____, imitate ____ ?

NOTES:

SEQUENCE OF DEVELOPMENT

OBSERVATION SUGGESTIONS

3-6 months

Watches own hand movements

If not observed spontaneously, facilitate position.
Does infant stare at hand or watch hand movement? _____
Ask caregiver if this occurred at an earlier age. _____ Hand regard is age-specific, and may not occur in an older infant.

NOTES:

Alternates gaze from one object to another

Hold two brightly colored blocks or popbeads 12" in front of infant's face. Gently shake one and then the other, several times.
Is infant able to shift back and forth at least three times? _____
If response is questionable, use rattles or bells.

NOTES:

*Approaches mirror image

Hold mirror directly in front of infant, about 12" away.
Does infant move head toward mirror? _____
Stare/smile at mirror image? _____
Reach toward mirror? _____

NOTES:

* For all items which require a motor response, note if infant has impairments which would limit responses.

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SEQUENCE OF DEVELOPMENT

OBSERVATION SUGGESTIONS

3-6 months (continued)

Reaches for caregiver's face

In face-to-face position, does infant reach toward caregiver's mouth, nose, glasses? _____

NOTES:

Tracks rolling ball

With infant propped on tummy or in supported sitting, roll 1" ball across floor or table surface within infant's visual field.

Does infant track with head and eyes _____, with eyes alone _____?

Does infant stare at place where ball was last seen _____, or turn to look for ball when it is out of visual field _____?

NOTES:

Reaches for dangling toy

Suspend a plastic ring by bright yarn, within infant's reach. Does infant reach toward and grasp ring? _____

Dangle ring at midline and to both sides.

Is infant able to locate ring in each position? _____

Note if infant consistently over or underreaches.

NOTES:

SEQUENCE OF DEVELOPMENT

OBSERVATION SUGGESTIONS

7-10 months

Looks at small object, e.g.
cheerio or raisin

Place object directly in front
of infant, within easy reach.
Does infant fixate on it? ____
If not, point to and tap object
to attract infant's attention.
Or increase contrast, e.g., place
object on a red placemat.

NOTES:

Attends to scribbling or
writing

Seat infant on your lap while
you are taking notes.
Does infant watch as you
write? ____ Attract infant's
attention by tapping pen on
paper; say "around and around"
or "zip" as you make circles
and straight lines.

NOTES:

Looks at pictures in book

Present infant with bright, clear
pictures in a cardboard book.
Does infant look at pictures? ____
Vocalize ____ or point to
pictures? ____

NOTES:

SEQUENCE OF DEVELOPMENT

OBSERVATION SUGGESTIONS

11-12 months

Explores depths by looking into containers

Drop a block in a coffee tin or cannister. Shake it and offer to infant.

Does infant peer into container? _____

NOTES:

Recognizes familiar objects across room (8-10 feet)

Place favorite toy (do not take from infant), across room, directly in front of infant. Does infant stare at toy? _____ Vocalize _____, reach _____ or move toward it? _____

NOTES:

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